

Prescriber Criteria Form

Tadalafil BPH 2026 PA Fax 6552-A v1 010126.docx

Cialis 2.5 mg, 5 mg Only (tadalafil 2.5 mg, 5 mg only), Chewtadzy 5 mg (tadalafil chewable 5 mg)  
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Tadalafil BPH.

Drug Name (select from list of drugs shown):

**Patient Name:**

**Patient ID:**

**Patient DOB:** **Patient Phone:**

**Prescriber Name:**

**Prescriber Address:**

**City:** **State:** **Zip:**

**Prescriber Phone:** **Prescriber Fax:**

**Diagnosis:** **ICD Code(s):**

**Please circle the appropriate answer for each question.**

1	Is the requested drug being prescribed to treat ONLY erectile dysfunction? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for the treatment of benign prostatic hyperplasia (BPH)? [If no, then no further questions.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to both of the following: A) alpha blocker, B) 5-alpha reductase inhibitor (5-ARI)?	Yes	No

Comments: \_\_\_\_\_

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_